WASHINGTON STATE BOARD OF PHARMACY
PHARMACIST PRESCRIBING PROTOCOL REVIEW FORM

For Review by Protocol Applicant and Board
WAC 246-863-100

Date: _____
Pharmacist Applicant: _____
Practice Site & Address: _____
Telephone # / FAX # / Email _____
Name of Protocol: _____
Authorizing Prescriber: _____
Practice Site/Address/ Phone #/Fax #/Email (if different) _____

	Applicant	Board Staff	Comments
1. Does the protocol contain a signed statement delegating prescriptive authority to pharmacist?			
2. Is authority delegated to other pharmacists under the supervision of the named pharmacist?			
3. Does the protocol agreement exceed two years?			
4. Is delegated authority within the physician's scope of practice?			
5. Does the protocol specify patients who are eligible to receive services under the agreement.			
6. Are delegated prescribing activities specified (e.g., disease, drugs, categories)?			
7. Does the protocol include controlled substances?			
8. Does the protocol specify types of pharmacist prescriptive authority (e.g., continuation, modification, initiation)?			
9. Does protocol contains a plan, guideline, or protocol for making prescribing decisions?			
10. Does the protocol specify procedures for documenting prescribing decisions?			
11. Does the protocol specify a plan for periodic feedback/review of the authorizing prescriber's prescribing decisions?			
12. Are all forms used attached?			
13. Description of quality assurance.			
14. Description of pharmacist training (Special training is required for Immunization and Emergency Contraceptives).			

Comments:_____

_____

FOR STAFF USE ONLY

Renewal _____ New ____ Reviewer: _____ Renew by: _____

Staff Recommendation: Acceptance _____ Revision Needed _____Board Agenda_____